101.11 THE REDETERMINATION PROCESS

Redetermination is the process of verifying whether a recipient continues to meet the eligibility requirements of a particular program. Redeterminations are classified as either regular or special reviews.

A regular review is an annual review of all eligibility factors. A special review is completed when a portion of the case must be re-worked or case information must be updated because of a change.

This chapter contains information about the redetermination process. General information about regular redeterminations is discussed first, followed program-specific discussions about the regular review process. Client notification, change reporting requirements, special reviews, corrective action and reinstatements are also included in this chapter.

GENERAL INFORMATION

101.11.01 REGULAR REDETERMINATIONS

Federal regulations require that the eligibility of every Medicaid and CHIP recipient be reviewed at least every 12 months. Mississippi state law also requires annual reviews. During the regular redetermination process, the recipient's entire situation is reviewed and each eligibility factor is evaluated in a process similar to the initial eligibility determination.

However, in completing the redetermination specialists should only request verification that relates to circumstances that are subject to change, such as income and resources. Recipients must not be asked to provide information that is not relevant to ongoing eligibility or that has already been provided and is not subject to change

Like the application process, a redetermination includes completing an application form, obtaining required verifications and evaluating the information to make an eligibility decision. It also includes a system review, including checking SVES, SDX, BENDEX, and reviewing all screens in MEDS or MEDSX and updating the information as needed.

101.11.02 ASSIGNMENT OF REVIEW DUE DATES

A regular review must be completed on each recipient at intervals not to exceed 12 months. Both MEDS and MEDSX automatically set a 12-month review at application and redetermination as follows:

- In MEDS, the review due date is set 12 months from the month in which the supervisor authorizes the application or redetermination action.

- At application, MEDSX sets the CHIP review due date 12 months from the CHIP effective month. The Medicaid review due date is set 12 months from the application month.

  When the 12-month eligibility period is set by the system, retroactive Medicaid months are not included in the 12-month count. Refer to the FCC program section for instructions for authorizing the continuous eligibility when a child is eligible only in a retroactive month(s).

  At review MEDSX sets the review due date 12 months from the from the time span begin date on the Time Period Selection screen for both Medicaid and CHIP.

The reviewing supervisor is responsible for ensuring the proper review due date is assigned to each individual and for correcting or adjusting system-assigned dates at authorization when needed.

While children are assigned a 12-month review, adults may be reviewed more frequently based on case circumstances and the likelihood of changes. However, no individual's review due date may be adjusted to exceed 12 months.

101.11.03 TIMELY PROCESSING

It is important for redeterminations to be completed in a timely manner to prevent overdue cases. Since a recipient's eligibility does not expire, benefits continue until the agency completes the review and an eligibility decision is made to either approve or terminate coverage. A review becomes overdue when more than 12 months have passed since the last eligibility determination. It is the responsibility of regional office staff to ensure reviews are processed timely.

When to Begin Processing a Review

It is permissible to begin the review process as early as the 10th month of a 12-month eligibility period or no more than 2 months early. However to ensure timeliness, the review process must begin no later than the month prior to the review month. This means for a case with a review due date of August, the redetermination process may begin as early as June, but must begin no later than July.

101.11.04 TIMELY AUTHORIZATION

The approval of a Medicaid redetermination is timely if it is authorized by the last day of the month in which the review is due. If Medicaid benefits are terminated, the action must be authorized no later than the adverse action deadline in the review month to be effective the following month. A CHIP approval is timely if it is authorized by the CHIP deadline in the month in which the review is due. A CHIP termination must be authorized no later than the adverse action deadline in the review month to be effective the following month.

When a redetermination closure is not authorized by the adverse action deadline in the review month, the case or individual is out of certification. However, an improper payment report is not required for the untimely closure. Ineligibility must exist for another reason for an improper payment report to be prepared.

Adverse Action Deadlines

In MEDS, the adverse action deadline is 12 days from the end of the month. Action must be taken by the adverse action deadline in the review month if coverage is to be terminated at the end of the review month.

In MEDSX if the Medicaid or CHIP termination action is authorized by the 19th of the month in which the review is due, the termination is effective at the end of the review month. An exception is February when the adverse action deadline in MEDSX is the 17th.

NOTE: Adults are not guaranteed 12 months of coverage. If termination is appropriate, the specialist will take action to terminate an adult's eligibility for the earliest possible month. However, coverage must be terminated no later than the adverse action deadline in the last month of the review period for the redetermination closure to be timely.

101.11.05 EXPARTE REVIEWS

Any recipient under review who is losing eligibility in one category of assistance is entitled to have eligibility reviewed and evaluated under any/all available coverage groups. The term "exparte review" means to review information available to the agency to make a determination of eligibility in another coverage group without requiring the individual to come into the office or file a separate application.

When to Complete an Exparte Determination

For an exparte determination to be made, the specialist must be in the process of making a decision on a current application, review or reported change. If the specialist is denying or closing for failure to return information or failure to complete the review process, an exparte determination is not applicable.

> **Example:** Jane Doe's CHIP eligibility will terminate because the family reports she is now covered under other health insurance. The specialist must review the record to see if it contains information which indicates the child has potential eligibility under another coverage group.
>
> **Example:** Recipient Tom Smith failed to comply with the annual review requirement and his eligibility must be terminated. The specialist does not complete an exparte determination.

Basis for the Exparte Review

The decision of whether the recipient is eligible under a different coverage group must be based on information contained in the case record. This may include income, household or personal information in the physical record which indicates the ineligible adult or child has potential eligibility in another coverage group. However, information received through electronic matches with other state/federal agencies such as a disability onset date or prior receipt of benefits based on disability are also part of the case record.

Obtaining Information to Make the Determination

When potential eligibility under another coverage group is indicated, but the specialist does not have sufficient information to make an eligibility determination, the recipient must be allowed a reasonable opportunity to provide necessary information.

Obtaining Information to Make the Determination (Continued)

Using DOM-307, the specialist will ask the recipient to provide verifications needed to determine eligibility in the new category. If the individual is an ABD recipient potentially eligible in an FCC category or vice versa, the request will include completion of the appropriate application form to collect required program information. An in-person interview is not conducted in the exparte review process even for a program that normally requires an interview.

Eligibility Decision

If the individual is subsequently determined to be eligible in the new category, the approval must be coordinated with termination in the current program to ensure there is no lapse or duplication in coverage. However, if requested information is not provided or if the information clearly shows that the recipient is not eligible under another category, eligibility in the current program will be terminated with advance notice.

During the advance notice period, the recipient is allowed time to provide all requested information to determine eligibility in the new program, provide information which alters the decision to terminate benefits in the current program or request a hearing with continued benefits. The specialist must take prompt and appropriate action to reinstate benefits when the recipient either provides all requested information needed to determine eligibility in another category, provides information which changes the termination decision in the current program, or requests a hearing with continued benefits during the advance notice period.

NOTE: When the recipient is determined ineligible in the new category, he does not have to repay the benefits he received while the eligibility determination was in process. However, if benefits are continued pending a fair hearing decision and the outcome is not favorable to the recipient, he is liable for repayment of the cost of services furnished solely because of the continuation of benefit provision.

Requested Information Provided After Closure

If the recipient subsequently provides all of the information needed to assess eligibility in the new program within 2 months of termination, the case should be handled in accordance with the procedures discussed in sections 101.11.07E and 101.11.08I.

EXPARTE REVIEWS (Continued)

Example: A CHIP review is due in May. On May 10th, the specialist determines the children's eligibility will terminate because of excess family income. She completes an exparte review of the case record and notes the SVES response for one child indicates the child has prior SSI eligibility. Since information available to the agency indicates a potential disability for this child, the specialist determines the child must be evaluated for another coverage group before her CHIP eligibility can be terminated. Since the exparte review does not indicate potential eligibility in any other coverage group for the other children, the specialist completes the closure action for them, leaving eligibility open for the potentially eligible child. She documents the case to support the action .

The specialist issues a 307 requesting a completed ABD application form and other information to determine Medicaid eligibility based on disability. The family does not respond to the request. On May 23rd after the 307 request period has expired, a 309, Second Request for Information, is issued. The family subsequently provides the required information. CHIP benefits remain open while the eligibility determination process continues.

On August 18th, the child is determined eligible in the Disabled Child Living at Home program. Her CHIP eligibility is terminated in MEDSX effective August 31st and Medicaid eligibility is authorized effective September 1st in MEDS.

- **Aged, Blind and Disabled Programs**

101.11.05A SSI REDETERMINATIONS

The SSI redetermination process is a type of exparte review. When individuals are terminated from SSI due to income and/or resources, they are issued an SSI Termination Notice and an SSI Redetermination Form, DOM-300B, by the fiscal agent upon receipt of SDX notification of termination. This form is to be completed and returned to the appropriate regional office if the recipient wants to apply for continued Medicaid coverage and is eligible under one of the coverage groups described in the SSI Termination Notice.

An in–person interview is not conducted, even if the program is one that normally requires an interview. However, all necessary factors of eligibility must be verified, such as disability, residency, utilization of benefits, etc. In addition, if other health insurance coverage is indicated on the 300B, TPL information must also be obtained.

SSI redeterminations have a 30-day processing standard, unless a DDS determination must be obtained.

101.11.06 METHODS FOR CONDUCTING A REGULAR REVIEW

Depending on the case type, the following methods are used to obtain a completed application form and other information needed to process a regular redetermination:

- In-Person Redetermination - When an in-person interview is required or requested, one will be conducted. If an appointment is needed, the specialist will issue the appointment via DOM-307, Request for Information, and include any information which is known to be needed on the request notice.

  This includes situations in which a recipient or representative comes to a more conveniently located regional office or out-station location to complete the redetermination on a case assigned to a different office.

- Mail-In Redetermination - For cases where a mail-in redetermination is permissible, the specialist will attach the application form to the DOM-307, include a request for any information which is known to be needed and mail it to recipient to complete and return.

- Telephone Redetermination – For cases where this is an option, the specialist may conduct a telephone interview and complete the application form based on the information provided by the recipient. A DOM-307 will be issued with the completed application attached for the recipient's review and signature. The request will also confirm other information which has to be provided by the recipient to complete the redetermination.

101.11.07 REGULAR REDETERMINATION PROCESS

- **Aged, Blind and Disabled Programs**

101.11.07A REDETERMINATION REPORTS

The Monthly MEDS Redetermination Due Listing (RJ076), sorted by regional office and caseload, identifies cases due and coming due for redetermination for a 3-month period. The report also lists any cases which are overdue as of the report date.

On a monthly basis, specialists will identify the cases assigned to them which are coming due for redetermination and begin the process to complete the application form and obtain any additional information needed for the review. As reviews are completed during the month, the specialist can use the RJ076W, Weekly MEDS Redetermination Due Listing, to identify cases which are still pending.

101.11.07B REQUESTING INFORMATION

Information is requested via DOM-307, Request for Information. If new or additional information, not included on the initial 307 is subsequently identified, another DOM-307 must be issued to request the information for the first time.

DOM-309, Second Request for Information, will be issued for any information requested via DOM-307(s) which is not submitted by the due date.

101.11.07C FOLLOW-UP CONTACT

When the client fails to provide all needed information, action cannot be taken to terminate ABD benefits due to failure to provide information without first attempting a telephone contact to inform the client of the information needed and when it must be provided to prevent termination due to non-receipt.

In addition, the recipient must also be informed that the case may be reinstated if all information is provided within the advance notice period and that a new application will not be required if the information is provided within 2 months of termination.

All efforts to contact the client must be documented in the case.

101.11.07D DISPOSITION

❖ **Aged, Blind and Disabled Programs**

Approval of Continued Benefits

When the client has complied with all redetermination requirements and provides required verifications, the specialist will review the eligibility criteria; ensure appropriate documentation is filed in the case record and input the data into MEDS for an eligibility decision. All redeterminations are submitted for supervisory review and authorization. When eligibility will continue at the same level, a new review due date is established and an approval notice issued to the recipient when benefits are authorized.

Reduction or Termination of Benefits

Advance notice of adverse action is required, if the eligibility decision results in

- Termination of benefits;
- Conversion to a reduced services coverage group;
- Increase in the amount of patient liability
- Termination of a nursing facility vendor payment.

During the advance notice period, the recipient is allowed time to fully comply with unmet redetermination requirements, provide information or verification that will alter the decision to terminate or reduce benefits, or request a Fair Hearing with continued benefits.

MEDS is not programmed for the case to remain open during the adverse action period; however, eligibility staff must treat the case as if it is open until the period has ended. During this period if the client subsequently complies with all redetermination requirements or provides information which changes the negative action, eligibility must be re-processed. If the client requests a hearing, with continued benefits, the case must be promptly reinstated.

Specialists must take prompt action on the information provided during the advance notice period. Timely action must be taken to prevent a break in coverage, whether the client takes action within the first few days of the adverse action period or on the final day.

Reduction or Termination of Benefits (Continued)

Example: The recipient did not provide income verification needed for the May redetermination. The closure is authorized on May 10th and advance notice is mailed to the client advising that eligibility will terminate effective May 31st. On May 18th, within the advance notice period, the verification is received in the office. The specialist takes action to process the case as a reinstatement and determines eligibility using the current income. The supervisor then reviews the action and authorizes the eligibility decision. Appropriate notice is issued to the client and there is no break in coverage.

101.11.07E COMPLIANCE AFTER CLOSURE

When the ABD client fully complies with redetermination requirements after closure, a reapplication is not required if the following is met:

- The case has been closed for 2 months or less at the time of full compliance.

  Example: The ABD recipient did not comply with review requirements for a May redetermination. The closure is authorized on May 10th effective May 31st. If the client fully complies by July 31st, eligibility can be determined using the reinstatement process. After July 31st, a reapplication must be filed.

The specialist is responsible for taking action within 48 hours of full compliance to register the reinstatement in MEDS. If the reason for closure is failure to provide requested information, the case will be processed using the most recently completed application form. There is no requirement to re-interview the recipient, if applicable, or obtain an updated signature on the application form. If redetermination requirements are not fully met during the 2-month timeframe, a reapplication is required.

Partial Compliance After Closure

If the recipient partially complies with redetermination requirements after case closure, a telephone contact will be attempted to inform the recipient of the action or information still needed. All efforts to contact the client must be documented in the case.

101.11.08 REGULAR REDETERMINATION PROCESS

- **Families, Children and CHIP Programs**

101.11.08A FREQUENCY OF REVIEWS

A full review must be conducted for all FCC case members in the situations discussed below:

- At the earliest 12-month review when case members have different review due dates;

  When a redetermination is currently due for some, but not all case members, the annual redetermination will be completed on everyone to attempt to align redetermination dates for the following year and assure one annual review for the family.

- When an application is filed to add a new biological/legal child or legal parent to the case;

  In this instance, the specialist will enter an application contact in MEDSX for the applicant(s) and a redetermination contact for other case members to process eligibility on everyone.

NOTE: If the HOH complies with redetermination requirements, but has had insufficient time to receive the appropriate documents to verify enumeration for a deemed eligible newborn, a review will be completed for children who are currently due. The deemed eligible baby will then be reviewed at his assigned review date.

101.11.08B PROCESSING CHILDREN CURRENTLY DUE FOR REVIEW

If a child, currently due for review, is determined ineligible or will have a program change from Medicaid to CHIP or vice versa, the action must be effective at the end of the current 12 month review period. To process the termination or change in MEDSX, the specialist will enter the month following the child's review due month as the time span begin date.

Example: The child's review due date is May. The time span begin date is set for June. If timely action is taken by the adverse action deadline in May, a termination will be effective May 31st. If a program change is involved in this example, action must be taken by the CHIP deadline in May for the program change to be effective June 1.

❖ **Families, Children and CHIP Programs**

101.11.08C PROCESSING CHILDREN NOT CURRENTLY DUE FOR REVIEW

Each FCC child must be provided 12 months of continuous eligibility in his eligible category. Prior to the end of the 12-month period, a child cannot be:

- Terminated, unless an early termination reason exists, or
- Changed from one program to another (Medicaid to CHIP or vice versa) unless the HOH voluntarily requests early closure in the current program or the original determination was in error.

Termination

When the family's redetermination results in ineligibility for a child with a review due date in the future, the child's termination must be effective at the end of his 12 months of continuous coverage.

> **Example:** May is the earliest review date for the case; however, one child is not due until August. To process a termination, this child's time span begin date is set for September, while the span for the other children is set for June. If timely action is taken by the adverse action deadline in May, the children due for review in May will be terminated effective May 31. The child due for review in August will terminate effective August 31.

Program Change

When a program change is involved for a child with a future review date, the change cannot be made until the end of the child's current eligibility period unless the HOH voluntarily requests early termination in the current program. This request must be made in writing via the Request to Close Prior to End of 12 Months form or other written statement requesting early closure and signed by the HOH.

> **Example:** May is the earliest review date for the case; however, one child's review date is August. If a program change from Medicaid to CHIP results, this child will continue to be Medicaid-eligible through August with CHIP coverage effective September 1st unless the HOH requests early Medicaid termination. If the HOH does request early Medicaid termination, the time spans of all the children will be set for June and the case processed for CHIP effective June 1. If the HOH does not request early termination, the time span begin date of the child due in August will be set for September and he will move to CHIP September 1 while his siblings go to CHIP June 1.

❖ **Families, Children and CHIP Programs**

Program Change (Continued)

The Request to Close Prior to End of 12 Months form is not necessary if all children in the case are currently due for review; therefore, the form must not be completed on a wholesale basis on every case. As the above example indicates, the form should be discussed with the HOH to facilitate an early program change for a child with a future date to place the child in the same program as siblings and align review due dates for the family's convenience. If the form is not completed, the child with the future review date will move to his new program at the end of his current eligibility period.

Processing an Application and a Review

As previously indicated, when an application is filed to add a new biological/legal child or a legal parent applying for 85 or pregnant woman applying in 88 to an active case, a review is completed for existing case members at the same time the application for the new member is processed as the following examples illustrate:

Addition of Legal Parent to Active Case for 85 Eligibility

Example: The children are active in CHIP; however, their mother lost her job and files an application including a request for herself on May 1st. An application contact is set for the adult and a redetermination contact is set for the children. The mother's time period begin date is May ongoing. The children's time period begin date is set for July, the next possible month a change can be made in CHIP eligibility. The family is subsequently determined to be eligible for 85 and the approval is authorized on May 20th. The mother is approved in 85 beginning May. The program change to 85 for the children is effective July.

Example: The children are active in 91 Medicaid; however, their mother lost her job and files an application including a request for herself on May 1st. An application contact is set for the adult and a redetermination contact is set for the children. The time period begin dates for the mother and children are set for May ongoing. The family is subsequently determined to be eligible for 85 and the approval is authorized on May 20th. The 85 effective date for mother and children is May.

Addition of Pregnant Woman to Active Case for 88 Eligibility

A pregnant woman can elect to include or exclude children from her application. If her children already have active coverage in Medicaid or CHIP at the time she files her application, the children must be included in the 88 eligibility determination and a review must be completed for them at the same time the mother's application is processed. The following example illustrates:

> **Example:** The children are active in CHIP with a review due in September; however, their mother files an application in May as a pregnant woman. An application contact is set for the mother and a redetermination contact is set for the children. The mother's time period begin date is May ongoing. The children will be eligible in 87 Medicaid based on current income and the increased need standard. The mother does not want CHIP eligibility to be terminated early and does not sign the closure request form. The children's time period begin date is set for October. Eligibility is authorized on May 20th as follows: 88 Medicaid for the mother beginning May and 87 Medicaid for the children effective October.

101.11.08D ASSIGNMENT OF REVIEW DUE DATES

Setting the correct time span at review is important for FCC cases to ensure 12 months of continuous eligibility is provided for children. MEDSX sets the review due date from the time span begin date on the Time Period Selection Screen. When completing an FCC review, the specialist should set time spans in MEDSX as follows:

- **Overdue for Review** - Set the time span for the month following the month of the interview. Children who are approved will have a new review due date 12 months from the time period begin month. Ineligible children will be terminated by the adverse action deadline for the next possible month.

  Also refer to 101.11.08C above for instructions on handling children in an overdue case who have future review due dates.

- **Current Reviews** - Set the time span for the month following the earliest redetermination due date for the case. This is the starting point to begin the eligibility assessment. If all children are approved again in the same program, the new review dates will be 12 months from the time period begin month.

  However, if a program change or termination results for children with a future review date, it will be necessary to adjust the time spans of those children to allow them 12 months of continuous coverage. Also refer to 101.11.08C above.

- **Early Reviews** - Begin the time span with the month following the earliest redetermination due month for the case. This is the starting point to begin the eligibility assessment. If all children are approved again in the same program, the new review dates will be 12 months from the time period begin month.

  If a program change or termination results, it will be necessary to adjust the time spans of children with future review dates to allow 12 months of continuous coverage prior to termination or program change. Also refer to 101.11.08C above.

  When caseload adjustments are needed to equalize the number of reviews due the following year, it is also permissible to set the time span for an early review to begin the month following the month of the interview. The case should be documented when this action is being taken. Instructions at 101.11.08C must be followed for children with future review due dates.

❖ **Families, Children and CHIP Programs**

ASSIGNMENT OF REVIEW DUE DATES (Continued)

If termination or a program change is involved for a child with a future review date whether the case has other members who are currently due, overdue or being completed early, the time spans must be adjusted to ensure the child receives 12 months of continuous coverage prior to the effective date of termination (unless there is an early termination reason) or program change..

A change from Medicaid to CHIP and vice versa does not require advance notice; however, the issue of continuous eligibility must be properly addressed prior to a program change and the change must be authorized by the CHIP deadline to be effective the following month.

❖ **Families, Children and CHIP Programs**

101.11.08E NOTICE OF UPCOMING REVIEW

A system-generated Notice of Upcoming Review is issued to FCC Heads of Household two months prior to the earliest review due date for the case. This notice informs the family of the impending review and provides general information which will be needed to complete the redetermination process.

101.11.08F REDETERMINATION REPORTS

The Monthly MEDSX Redetermination Due Listing (RJ431), sorted by regional office and caseload, identifies the cases due and coming due for redetermination for a 3-month period. The report also lists any cases which are overdue as of the report date.

On a monthly basis, each specialist will identify cases subject to redetermination and begin the redetermination process to complete the application form and obtain additional information to complete the review. As reviews are completed during the month, the specialist can use the RJ431W, Weekly MEDSX Redetermination Due Listing, to identify cases which are still pending.

101.11.08G SCHEDULING THE INTERVIEW AND REQUESTING INFORMATION

The specialist will issue an interview appointment via DOM-307, Request for Information. FCC review appointments must be scheduled to allow a minimum of 14 days between the appointment notice and the date of interview. Information known to be needed will also be requested on this 307. In this instance, the information due date is the day of the interview.

If additional information is determined to be needed at the interview or the client requests additional time to provide some or all of the previously requested information, a second DOM-307 will be issued.

101.11.08H DISPOSITION

Approval of Continued Benefits

When the head of household complies with redetermination requirements and provides required verifications, the specialist will review all eligibility criteria, ensure appropriate documentation is filed in the case record and input the data into MEDSX for an eligibility decision on the case members.

❖ **Families, Children and CHIP Programs**

Approval of Continued Benefits (Continued)

All redeterminations are submitted for supervisory review and authorization. When eligibility will continue, a new review due date is established based on the time span set for each individual and an approval notice is issued to the HOH.

Termination of Benefits

Advance notice of adverse action is required, if the eligibility decision results in termination of benefits for all or some members of the case. During the adverse action period, the head of household is allowed time to fully comply with unmet redetermination requirements, provide information or verification that will alter the adverse action decision or request a Fair Hearing with continued benefits.

MEDSX is not programmed for the case to remain open during the adverse action period; however, eligibility staff must treat the case as if it is open until the adverse action period has ended. If the client subsequently complies with all redetermination requirements, provides information which changes the negative action or requests a Fair Hearing within the advance notice period, eligibility must be reinstated to prevent a loss of benefits.

In MEDSX, there is no reinstatement function, an application contact is required for any person with a status of denied ongoing. Otherwise, a notice will not be generated. Prompt action must be taken to prevent a break in coverage, whether the client takes action within the first few days of the adverse action period or on the final day. This is applicable for FCC Medicaid programs and CHIP.

Preventing a break in coverage is accomplished more easily in Medicaid than CHIP due to the CHIP processing deadline. When the CHIP client fully complies within the adverse action period and before the CHIP deadline, action must be taken to reverse the termination and ensure benefits are authorized for the following month with no break in coverage.

When the client complies after the CHIP deadline, but still within the adverse action period, eligibility must be re-established for the next possible month. CHIP agency error procedures should be followed for months of lost benefits.

❖ **Families, Children and CHIP Programs**

Termination of Benefits (Continued)

If the FCC head of household is subsequently interviewed within the adverse action period, but fails to provide requested information during this timeframe, application rules apply. An eligibility decision must be made within the 30 days.

Example: The head of household failed to meet the interview requirement for a May redetermination. The case was closed on May 19th effective May 31st. On May 29th the interview requirement is met; however, information needed to process the case is not provided. An application contact is registered for May 29th. A 307 is issued for the information and 30-day processing is applicable.

❖ **Families, Children and CHIP Programs**

101.11.08I REQUESTED INFORMATION PROVIDED AFTER CLOSURE

After closure, a new application form is not required to determine eligibility for the case or an individual if the following requirements are met:

- The head of household subsequently provides all information needed to complete the redetermination; **and**

- The case has been closed for 2 months or less at the time the information is provided based on the earliest termination date for the case; **or**

- For an individual who was currently due for review, the individual has been terminated for 2 months or less at the time the information is provided;

  or

- If the only child who is terminated has a future date, the information is provided within 2 months of the month in which the action was taken to terminate eligibility.

  The following example illustrates:

  Example: Three children in the case are due for May review and one child is due in August. The head of household failed to verify income. On May 10th action was taken to terminate eligibility effective May 31st and August 31st, respectively. The income verification must be provided by July 31st based on the earlier effective date for the case.

  If the child with the future termination date of August 31 was the only child in this case who was terminated on May 10th, the information which caused the child's termination must be provided no later than July 31st within 2 months of May, the month in which the termination action was taken.

❖ **Families, Children and CHIP Programs**

REQUESTED INFORMATION PROVIDED AFTER CLOSURE (Continued)

There is no requirement to re-interview the head of household or obtain an updated signature on the application form. The specialist is responsible for registering the case within 48 hours of receipt of the information. As previously indicated, there is no reinstatement function in MEDSX, an application contact is required to determine eligibility and issue proper notification for any person with a status of denied ongoing. If all requested information is not provided during this 2-month timeframe, a reapplication must be filed.

Incomplete Information Provided After Closure

If only part of the information is provided, a telephone contact will be attempted to inform the recipient of the information which is still needed. All efforts to contact the client must be documented in the case.